

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050256

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3980

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN JEFFERSON BARRACKS, MO. | | c. CITY OR TOWN FLORISSANT | |
| Length of stay in 1b 55 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMIN. HOSPITAL | | d. STREET ADDRESS (If outside, give location) 2095 DUNN ROAD | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) THOMAS N. JOHNSON | | 4. DATE OF DEATH 12-25-63 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-6-21 |
| 9. AGE (last birthday) 42 YEARS | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10b. KIND OF BUSINESS OR INDUSTRY NAVAL | |
| 11. BIRTHPLACE (City and state or country) St. LOUIS, MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME JOHNSON, ELMER | | 13b. MOTHER'S MAIDEN NAME SMITH, MILDRED | |
| 14. NAME OF HUSBAND OR WIFE NONE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-2 | |
| 16. SOCIAL SECURITY NO. [REDACTED] | | 17. INFORMANT ELMER JOHNSON (Father) 2095 Dunn Road Florissant, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY INSUFFICIENCY ACUTE & CHRONIC SEVERE BILATERAL PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) EARLY LAENNEC'S CIRRHOSIS OF LIVER | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. attended the deceased from 10-31-63 to 12-25-63 Death occurred at 6:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. SIGNATURE (Degree or title) John J. Mueller M.D. M.D. VET. ADM. HOSP., JEFF. BRKS., 25, MO. | |
| 22b. ADDRESS | | 22c. DATE SIGNED 12-25-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 12/27/63 | 23c. NAME OF CEMETERY OR CREMATORY NATIONAL | 23d. LOCATION (City, town, or county) (State) ST LOUIS CO. MO. |
| 24. FUNERAL DIRECTOR Leah Zieser Linton MO. | 25. DATE RECD. BY LOCAL REG. 12-27-63 | 26. REGISTRAR'S SIGNATURE John J. Murphy M.D. | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ronald J. Mahan
Licensed Embalmer No. 4975
P. O. Address De Soto, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.